Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HEALTHCARE NORTH DALLAS
PO BOX 1210
FRISCO TEXAS 75034

Respondent Name
GREAT MIDWEST INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-2651-01

MFDR Date Received
June 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached date of service 3/20/13 was denied, and is a Physical Therapy Followup [sic] Evaluation. The initial Physical Evaluation was billed on 3/6/13, and PAID in full. I have attached the payment EOB for 3/6/13 date of service. This was resubmitted 5/1/13, and additional documentation was requested. I then sent 44 pages of documentation per request. Then, on 5/8/13, it was denied again. It is contradicting and inconsistent that they would pay one, but not the other. I have attached all necessary documentation."

Amount in Dispute: $69.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 was placed in the insurance carrier's representative box on June 24, 2013 and stamped received by FOL Fileroom Gordon Clayton on June 25, 2013. A decision will therefore be issued based on the documentation contained in the file at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2013	97002	$69.18	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedure for medical bill submission by health care provider.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 16, 18, 193, GP – No tall info needed for adjudication was supplied. Duplicate claim/service, original payment decision maintained. Service delivered under OP PT care plan.
   - 193, B13, GP – Original payment decision maintained. Payment for service may have been previously paid. Service delivered under OP PT care plan.
   - B30, GP – Srvc partially/fully furnished by another provider. Service delivered under OP PT care plan. Per rule 133.20 (e)(2), a medical bill must be submitted in the name of the licensed health care provider that provided health care or that provided direct supervision of an UNLICENSED individual who provided the healthcare. Silvey PT is rendered HCP.

Issues

1. Did the requestor submit the bill in accordance with the provisions of Texas Labor Code §401.011?
2. Did the requestor submit the bill in accordance with the provisions of 28 Texas Administrative Code §133.20?
3. Is the requestor entitled to reimbursement?

Findings

1. Texas Labor Code §401.011, titled, General Definitions, states in pertinent part. “In this subtitle... (21) "Health care practitioner" means: (A) an individual who is licensed to provide or render and provides or renders health care; or (B) a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor.
2. Per 28 Texas Administrative Code §133.20 "(d) The health care provider that provided the health care shall submit its own bill, unless: (1) the health care was provided as part of a return to work rehabilitation program in accordance with the Division fee guidelines in effect for the dates of service; (2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill."

   28 Texas Administrative Code §133.20, titled, Medical Bill Submission by Healthcare Provider, states in pertinent part, (e)(2) states in pertinent part “(e) A medical bill must be submitted: 2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care...”

   - Review of the documentation for CPT code 97002 documents that the requestor provided a physical therapy re-evaluation examination. No documentation to support that the service was part of a return to work rehabilitation program or that the services were provided by an unlicensed individual under the direct supervision of a licensed health care provider.
   - Review of the CMS-1500 for date of service March 20, 2013 notes in box 31 the signature of physician or supplier as Jeff Hicken, D.C.
   - Review of the “Physical Therapy Evaluation” indicates that SL Silvey, PT rendered the services (CPT code 97002) on March 20, 2013. The requestor further indicates on the EOB dated April 10, 2013 that Steve Silvey is a licensed therapist employed by Elite Healthcare.
   - The requestor did not meet the billing requirements of 28 Texas Administrative Code §133.20. As a result reimbursement cannot be recommended for the disputed CPT code 97002 rendered on March 20, 2103.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September 13, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.